Please make a copy for your records. Athletics is NOT responsible for lost physicals

PREPARTICIPATION PHYSICAL EVALUATION-HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name:_____ Date of birth: _____ Age: _____ Grade: _____

Sex assigned at birth (F, M, or intersex):_____ How do you identify your gender? (F, M, or other): _____

Address: _____ City:_____ Zip:_____

Phone: _____ School:_____ Sport(s): _____

Date of examination: _____

List past and current medical conditions.

_____

Have you ever had surgery? If yes, list all past surgical procedures.

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

PATIENT HEALTH QUESTIONNAIRE VERSION 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle Response.)

	Not at all	Several Day	Over half the day	Nearly every day
Feeling Nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes)

COVID-19

Have you had COVID-19? ☐Yes ☐No Previously received COVID-19 vaccine: ☐Yes ☐No Administered COVID-19 vaccine at this visit: ☐Yes ☐No
If yes, ☐1st Dose ☐ 2nd Dose

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had, or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

I hereby state, that to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

This form MUST be signed by a parent and the athlete.

Do NOT give the physical paperwork to your coach. It MUST be submitted to the Athletic office.

Physical Examination & Medical Eligibility Form

LAST:_____ FIRST:_____ MIDDLE:_____

DATE OF BIRTH:_____/_____/_____ AGE:_____ GRADE: 9 10 11 12 (CIRCLE ONE)

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms.

EXAMINATION			
Height:	Weight:		
BP: / (/)	Pulse:	Vision: R 20/ L 20/	Corrected: ☐ Yes ☐ No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart • Murmurs (auscultation standing, supine, ± Valsalva)		
Lungs		
Abdomen		
Skin • Herpes simplex virus, [HSV], lesions suggestive of MRSA, tinea corporis		
Neurological		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional (Double-leg squat test, single-leg squat test, box drop, or step drop test)		

Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

ELIGIBILITY STATUS (CHECK ONE):

- ☐ MEDICALLY ELIGIBLE FOR ALL SPORTS **WITHOUT RESTRICTION**
- ☐ MEDICALLY ELIGIBLE FOR ALL SPORTS **WITHOUT RESTRICTION** *WITH RECOMMENDATIONS* FOR FURTHER EVALUATION OR TREATMENT FOR:

  _____
- ☐ MEDICALLY ELIGIBLE FOR CERTAIN SPORTS _____
- ☐ NOT MEDICALLY ELIGIBLE PENDING FURTHER EVALUATION
- ☐ NOT MEDICALLY ELIGIBLE FOR ANY SPORTS

RECOMMENDATIONS: _____

I HAVE EXAMINED THE STUDENT NAMED ON THIS FORM AND COMPLETED THE PREPARTICIPATION PHYSICAL EVALUATION. THE ATHLETE DOES NOT HAVE APPARENT CLINICAL CONTRAINDICATIONS TO PRACTICE AND MAY PARTICIPATE IN THE SPORT(S) AS OUTLINED ON THIS FORM. A COPY OF THE PHYSICAL EXAM FINDINGS ARE ON RECORD IN MY OFFICE AND CAN BE MADE AVAILABLE TO THE SCHOOL AT THE REQUEST OF THE PARENTS. IF CONDITIONS ARISE AFTER THE ATHLETE HAS BEEN CLEARED FOR PARTICIPATION, THE PHYSICIAN MAY RESCIND THE MEDICAL ELIGIBILITY UNTIL THE PROBLEM IS RESOLVED AND THE POTENTIAL CONSEQUENCES ARE COMPLETELY EXPLAINED TO THE ATHLETE (AND PARENTS/GUARDIANS).

NAME OF HEALTH CARE PROFESSIONAL (PRINT)_____ DATE _____

SIGNATURE OF HEALTH CARE PROFESSIONAL_____ MD | DO | NP | PA (CIRCLE ONE)

DATE OF EXAM: / /

PLACE PHYSICIAN'S STAMP HERE